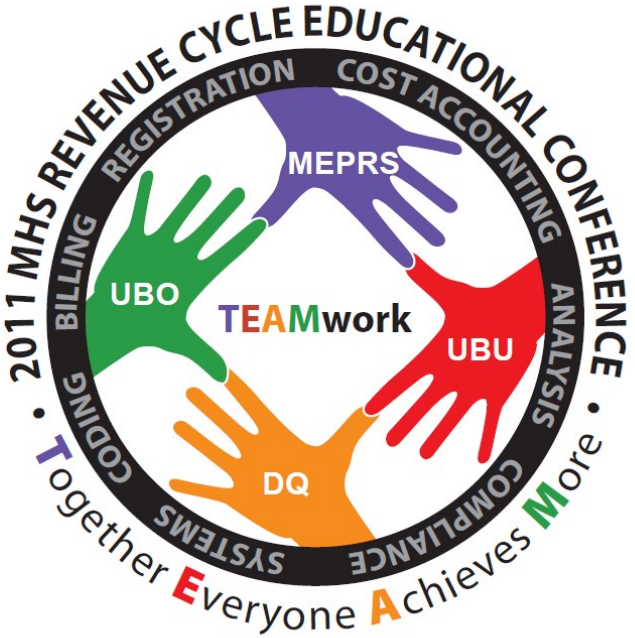


Title: **Coding for Compliance – E&M Leveling**

Session: **W-6-0900**

Objectives

- Define compliance issues associated with electronic medical records documentation
- Increase awareness of the essential components of E&M leveling within the EMR
- Identify areas for review with AHLTA vs. MHS Guidance
- Recognize relevant factors to be addressed in MTF Compliance Plan
- Learn resources available to provide understanding of AHLTA and MHS Coding as it relates to your Compliance Plan

EMR Compliance Issues

- The EMR tools drive documentation excessive for the severity of the presenting problem
- The EMR tools generate questionable documentation
- The templates generate multiple records with nearly identical text
- The templates default to multisystem reviews and exams whether physicians do them or not

EMR Compliance Issues

- Be aware of the pitfalls associated with the EMR
- Stay educated
- Guidance used to support:
  - Should be compelling
  - Should be persuasive
- Remain Cognizant:
  - Most guidance is billing related
  - Differentiate between MHS and industry
- Coding workshops
  - Filter information for what applies

Compliance Clarity for Documentation

- Define Documentation Guidelines
  - Overall MTF
  - Clinic specific
- Using 1995 vs. 1997 Documentation Guidelines
  - If the clinic is using 97 but 95 benefits it more, will you default?
- Default based on:
  - 1995 - 99213 (if not counting chronic conditions)
  - 1997 - 99214 (if counted)
  - Exam

AHLTA Impact on Compliance Plan

- E&M leveling enormous problem in audits
- Procedural coding with the click of the mouse
- Business Plan drives RVU hunt
- Physicians deal with:
  - Structured documentation, slow response time
  - Free text not captured
  - Template development
- AHLTA application contradicts/conflicts with documentation guidelines
- Result:
  - Auditors struggle to “unravel” pertinent documentation
  - Difficult to inspire compliance with physician

AHLTA E&M Factors

- Automated AHLTA E&M Calculation include but not limited to:
  - Vital signs data
    - BP, HR, RR, Temp, Ht and Wt – eliminates need for the provider to document — “vital signs reviewed”
  - The Total face-to-face option >50%
  - AutoCited Information; i.e., problems, allergies, meds, hx, lab/rad results
  - Diagnosis and Procedures for Medical Decision Making (MDM)
  - Orders for MDM Calculation
  - Service Type
  - Patient Status

Compliance Clarity for E&M leveling

- DoD Rule
  - AHLTA Documentation: Autocite information will not be considered when determining the appropriate ICD-9-CM, E&M, and/or CPT code to be assigned to the encounter, unless pertinent findings are acknowledged within the body of the providers' notes

Source: Military Health System Coding Guidance: Professional Services and Specialty Coding Guidelines Version 3.4, Effective date:
1 Jan 2011

Compliance Clarity for E&M leveling

- DoD requires the utilization of medical decision making as a mandatory component of an established patient E&M assignment. The facility may choose between History or Physical Exam for the second component.

Source: Military Health System Coding Guidance: Professional Services and Specialty Coding Guidelines Version 3.4, Effective date:|
1 Jan 2011

Compliance Clarity for E&M leveling

- Documentation criteria
  - 97 vs. 95 in clinic settings
  - ROS and “Double dipping”
  - What constitutes a “comprehensive hx” in Preventive Medicine?
  - What is an interval history and when does it apply?
- Resources
  - DoD, ICD-9, CPT, CMS otherwise known as Official
  - Specialty Specific; i.e., ACEP, PCP, etc.
  - Service specific
  - Google

Compliance Clarity for E&M leveling

- Define guidelines to be used by auditors
  - 97 E/M guidelines vs. 95 re EXTENDED HPI and status of three or more “chronic or inactive problems”
  - Comprehensive physical exam using the 1995 E/M guidelines
  - Mix of organ systems AND body areas for 1995 E/M guidelines
  - Use of questionnaire when completing the ROS and PFSH
- Define prescription drug management in the table of risk
- Define how auditors quantify the MDM
  - 95 or 97 documentation guidelines
  - AHLTA E&M calculations

Compliance Clarity for Documentation

3.1.1. Determination of Level of E&M Code

- When determining the level of history for an E&M code, the documented elements in the History of Present Illness (HPI) may also be counted in the Review of Systems (ROS) and the Past Family Social History (PFSH) when appropriate
- If nausea, vomiting, and diarrhea is documented in the HPI, it is not necessary to re-document “nausea, vomiting, and diarrhea” in the ROS section in order to count it in both elements of the history component
- More E&M documentation guideline information is on the CMS Web site at http://www.cms.hhs.gov/

Source: Military Health System Coding Guidance: Professional Services and Specialty Coding Guidelines Version 3.4, Effective date: 1 Jan 2011

Compliance Clarity for Documentation

3.1.1.1. Chief Complaint /HPI/ROS/PFSH

Chief complaint, should always be noted in the encounter documentation

Only those parts of the HPI that are actually documented by the provider may be used in calculating the level of the encounter

To certify that the provider reviewed the information documented by others, there must be a notation supplementing or confirming the review

Source: Military Health System Coding Guidance: Professional Services and Specialty Coding Guidelines Version 3.4, Effective date: 1 Jan 2011

Compliance Clarity for Documentation

3.1.1.2 Self-Limited/Minor Problems

- Clarifies a common error in E&M leveling
- Assign a self-limited or minor problem in the "Number of Diagnoses or Treatment Options" component of medical decision-making to the level of a new problem
- CPT defines a self-limited or minor problem as "a problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status, OR has a good prognosis with management/compliance"

Compliance Clarity for Documentation

- Define proper/improper phrase usage
  - “unremarkable” to identify if organ system or body area
  - “non-contributory” when is it acceptable
  - “counseled on condition” is it acceptable documentation
  - ROS, and “all other systems negative”
- Educate clinical staff
  - Physicians
  - GPM
  - Para-professionals

Documentation Dream

ESTABLISHED OFFICE VISIT ***Source: 2009 Coding for Compliance –***

Nxxxx Fxxxxxxx

CC: HTN and OA

HPI: The patient's HTN has been well controlled at home on DIOVAN 160 mg PO QD. OA remains stable on intermittent OTC IBUPROFEN. PFSH: none

REVIEW OF SYSTEMS: ROS: Extended (’95 & ’97) CV, Resp. (although lumped in under CV, could count Resp except questionable for “medical necessity but we’re not doctors)

CARDIOVASCULAR: Negative for chest pain, orthopnea, PND.

PHYSICAL EXAMINATION: GENERAL: NAD, conversant; looks younger than stated age. VITAL SIGNS: Blood pressure is 124/72, HR 84, RR 18. NECK: No JVD or carotid bruits. LUNGS: CTA. CARDIOVASCULAR: RRR. EXTREMITIES: Show no peripheral edema.

LABORATORY INFORMATION: No labs today.

IMPRESSION:

Optimally controlled HTN.

Stable OA.

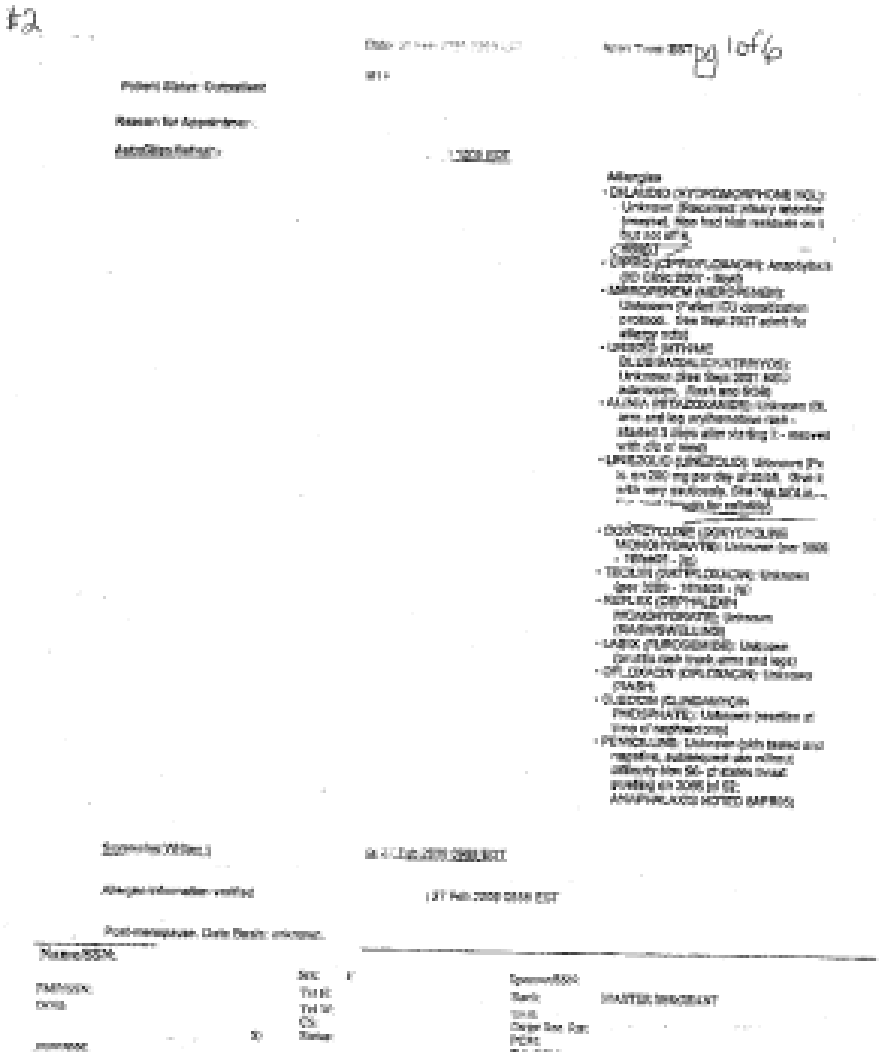
PLAN:

Continue current BP meds.

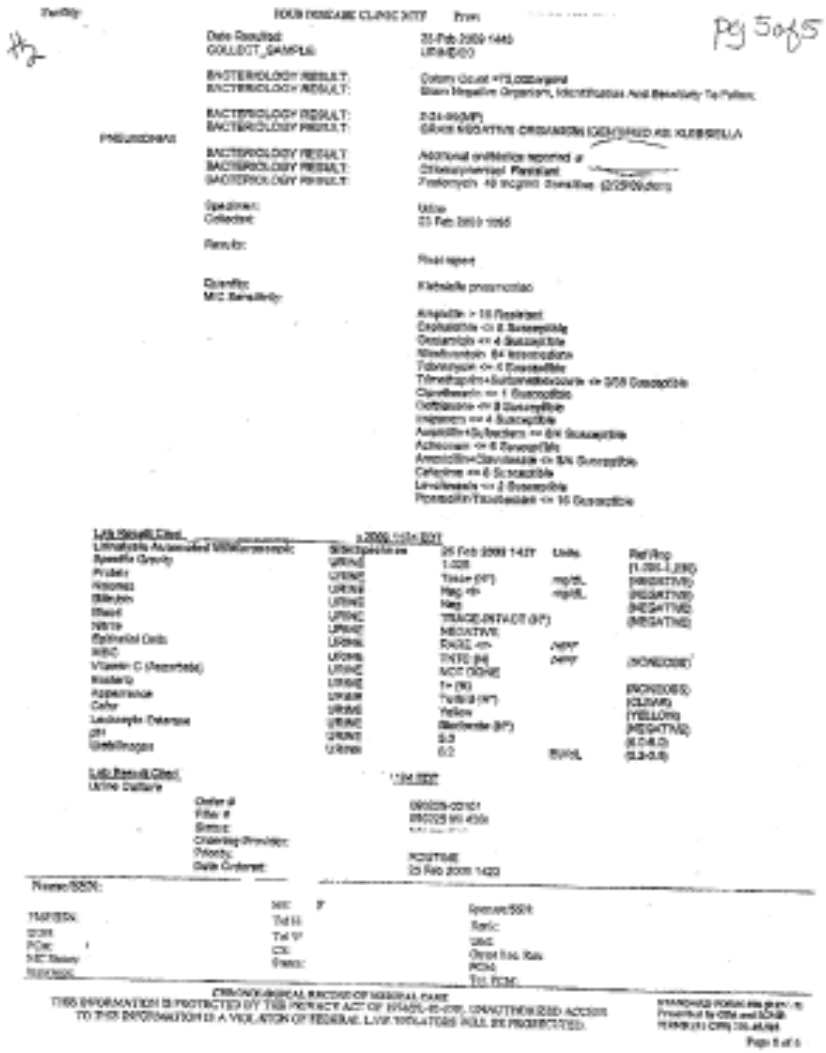
Continue PRN IBUPROFEN.

RTC in six months with renal profile and lipid panel.

Documentation Reality



Documentation Reality



Compliance Clarity for MHS Initiatives

- Define template and auditing forms for detailed information into the MTF Compliance Plan
  - Aims forms
  - Specialty audit forms
- Define “other”; i.e., service specific initiatives
  - *MEDCOM AHLTA Provider Satisfaction (MAPS)*
  - Operation COMPASS: Focus on Optimization (AF)
- Identify workload implications
  - Scope of practice
  - MTF initiatives

Compliance Clarity for Scope of Practice

- MTFs granted privileges and scope of practice
  - Physicians
  - Nurse practitioners and Physician Assistants
  - Independent Duty Corpsman (IDC), Independent Duty Medical Technicians (IDMT)
  - Oral surgeons, optometrists, etc.
  - Residents, post-graduate year one [PGY-1]
  - Clinical Pharmacists
  - Physical and Occupational Therapists
  - Nurse/Tech

Compliance Clarity for Responsibilities

- **1.6. Legal Reference:** The medical record is the legal record of care. When there is a difference between what is coded in the Ambulatory Data Module (ADM) and what is documented in the medical record, *a coder may change a code to more accurately reflect the documentation. When this occurs, the coder must notify the provider. The provider is ultimately responsible for coding and documentation.*

  While the data from the CHCS record can be used to create third-party claims, the medical record must support the coding in the claim.

Source: Military Health System Coding Guidance: Professional Services and Specialty Coding Guidelines Version 3.4, Effective date: 1 Jan 2011

Compliance Clarity – Conflicting Guidance

- Identify conflicting guidance and provide clear and distinct guidance
  - MHS Professional Services Guidelines
  - MHS Auditing Guidelines, Appendix F
  - UBO User Guide
  - Service Specific Coding Guidelines
  - Service Specific Workload Guidelines

Compliance Clarity for Service Setting

- Define workload services within specific settings
  - Rounds documented in AHLTA
  - Inpatient consults or “co-attending”
  - ED services for direct admits, self referrals, etc.
  - Clinic services for inpatients
  - Observation services
  - “incident to services”

These along with many other compliance issues addressed in the previous slides are defined in the MHS

Coding Guidelines they are still a compliance issue within the services.

Compliance Plan Considerations

- Update annually based on changes
  - Provide training on changes and revisions
  - Revisions with summary of changes
  - Maintain previous versions for historical purposes

<u>Your Compliance Plan is a living, breathing document</u>

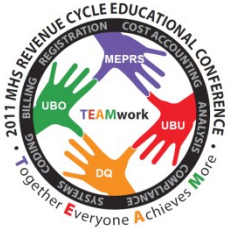
<u>that must be revised as the guidelines and environment within the MHS evolve</u>

Compliance Plan Summary

- Compliance Plan document should address issues to avoid degrees of variability:
  - AHLTA E&M calculator (97 vs. 95)
  - Clarity for E&M leveling (don’t reinvent the wheel)
  - MHS and Service-specific Initiatives
  - Scope of Practices
  - Ownership
  - Conflicting guidelines
  - Service Setting (inpatient/out-patient)

Resources

- Army http://pasba3.amedd.army.mil
- Air Force https://phsohelpdesk.brooks.af.mil
- Navy https://dataquality.med.navy.mil/reconcile/codinghotline/ticketentry.aspx http://www.usafp.org/AHLTA-3_3-Information-FAQs.htm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Questions?